5. Regulatory and Reporting Requirements

5.1 Reporting Requirements

Healthfirst is required to report to federal, New York City, and New York State regulatory authorities on a variety of data elements, including financial, clinical, and quality-related indicators. In order to maintain compliance with these requirements, Healthfirst relies upon its provider network to supply it with comprehensive, accurate, and timely information. Healthfirst expects its participating providers to follow all public health and regulatory guidelines related to the reporting of communicable diseases, the delivery of preventive care services, lead screening, procedure consents (e.g., sterilization/hysterectomy), child abuse and domestic violence, and any other required data sets. Please refer to Section 14 for more information.

Fraud, Waste & Abuse Hotline

If you suspect fraud, waste, or abuse by a Healthfirst member, by another provider, or by Healthfirst itself, **please call our Compliance Hotline at 1-877-879-9137,** which allows anonymous reporting and is staffed 24/7, **or visit** www.hfcompliance.ethicspoint.com. Fraud is broadly defined as intentional deception, or misrepresentation an individual knows to be false or does not believe to be true and makes regardless, knowing that the deception could result in some unauthorized benefit to himself/herself or some other person.

Examples of fraud, waste, and abuse include:

- Submitting inaccurate claims
- Billing for services that were not provided
- Accepting inducements to utilize or refrain from utilizing a service
- Using another person's Healthfirst Identification Card
- Failing to comply with Healthfirst policies

5.2 Medical Record Reviews and Documentation Standards

Well-documented medical records facilitate the retrieval of clinical information necessary for the delivery of quality care. In private office or clinic settings, the medical record is an essential tool for communication between providers.

Providers should be in compliance with professional standards and should take steps to safeguard confidentiality when sharing medical record information with other network providers.

Periodically, Healthfirst requests medical records and conducts reviews to evaluate practice patterns, to identify opportunities for improvement, and to ensure compliance with quality standards. In many instances such reviews are required under the Medicaid, CHPlus or Medicare Advantage programs. All Healthfirst medical record reviews are conducted by clinical professionals, and all information contained in the records is kept strictly confidential. Providers must make medical records available upon request by Healthfirst or by CMS, NYSDOH, or any other regulatory agency with jurisdiction over Medicaid, CHPlus, or Medicare Advantage programs.

The provision of enrollee personal health information and records for the purposes listed below constitute healthcare operations pursuant to 45 CFR 501, and therefore the member's explicit consent is not required for the release of such records and information to Healthfirst. However, the member's authorization to allow Healthfirst to review records is also obtained by Healthfirst at the time of the member's enrollment with Healthfirst.

Healthfirst reviews medical records as part of the following activities:

- Credentialing and recredentialing

- Clinical quality of care investigations
- Monitoring utilization to validate prospective and concurrent review processes, identify trends, assess level of care determinations, and review billing issues
- Monitoring for accuracy and completeness of coding
- Monitoring for compliance with approved Practice Guidelines and Standards of Care
- Reporting for Quality Improvement and Peer Review Organization studies and HEDIS® /QARR measure compliance
- Monitoring of provider compliance with public health regulations on reporting requirements
- Monitoring for compliance with Healthfirst Medical Record Documentation Standards

In addition, NYSDOH and Peer Review Organizations audit medical records as part of their respective quality review processes. If deficiencies are found after an internal medical record review or a review conducted by regulatory agencies, providers will be required to participate in a corrective action plan, as necessary.

Medical records must be maintained by practitioners who are providing primary care and referral services. They must be maintained for a period of six (6) years after the last visit date or, in the case of minor children, for six (6) years from the age of majority for New York State programs and ten (10) years for Medicare programs and for New York State of Health (NYSOH) enrollees.

Transfer of Medical Records

When transferring medical records from one participating PCP to another, a release of information form is not required. However, a release form must be signed when the member requests records to be sent to other entities outside of Healthfirst, such as other insurance companies. When a member transfers PCPs, providers must facilitate the transfer of medical records in a timely manner.

5.3 Confidentiality

A member's Protected Health Information (PHI) is sheltered under the contractual relationships between Healthfirst and the member and between Healthfirst and the provider. PHI includes enrollment with Healthfirst, medical records, and/or the payment for the provision of health services that are derived in whole or in part using personally identifiable information that is not otherwise publicly available. Such PHI must be safeguarded and held in strict confidence so as to comply with applicable privacy provisions of state and federal laws, including the Health Insurance Portability and Accountability Act (HIPAA).

Healthfirst members sign an authorization at the time of enrollment that allows Healthfirst to review, release, and use their respective PHI. In addition, at the time of the initial encounter with each Healthfirst member, providers are required to obtain the member's written consent to disclose personal health information to Healthfirst or provide the member with a copy of their Privacy Notice indicating that their PHI will be shared with Healthfirst and other entities. This written consent or the member's written acknowledgment of the provider's Privacy Notice is to be maintained in the provider's records and is subject to audit by Healthfirst. All providers should take all reasonable measures to protect the privacy and confidentiality of members' nonpublic personal information at all times and to prevent the use or disclosure to any nonaffiliated third party.

The provider understands and agrees that the provision of the enrollee's personal health information and records for quality assurance/utilization review pursuant to Section 2.5 and encounter data pursuant to Section 2.6 are healthcare operations pursuant to 45 CFR 501, and therefore the enrollee's consent is not required for the release of such records and information to Healthfirst.

All providers should remain aware that PHI about the provision of behavioral health and/or substance abuse services and PHI that identifies the presence of behavioral health, substance use disorders and/or HIV-related illness are governed by a special set of confidentiality rules. Release of these records requires a

special authorization. They should not be released to anyone other than the member except under tightly defined and controlled circumstances. If you have any questions regarding the disclosure of a Healthfirst member's information, please call **1-888-801-1660**.

All Medicaid providers are required to develop policies and procedures to assure confidentiality of behavioral health, substance abuse and HIV-related information, including the following information:

- Initial and annual in-service education of staff, contractors
- Identification of staff allowed access and limits of access
- Procedure to limit access to trained staff (including contractors)
- Protocol for secure storage (including electronic storage)
- Procedures for handling requests for behavioral health, substance abuse and HIV-related information
- Protocols to protect persons with or suspected of having behavioral health, substance use disorders and/or HIV infection from discrimination

5.4 Advance Directives/Health Care Proxy

All members, including Healthfirst members, have the right to make decisions about the amount and type of care that they will receive, including care if they are terminally ill. A terminal illness is defined as any illness that is likely to result in the death of a person within six months. Through the use of written Advance Directives, a Healthfirst member can ensure their wishes are known and followed in the event that they cannot make decisions for themselves.

Healthfirst members have the right to appoint a healthcare agent through a Health Care Proxy (Appendix VI). A Health Care Proxy is a formal document enabling a member to designate a trusted individual to make healthcare decisions on his/her behalf if the member is unable to make decisions themselves. All competent adults can appoint a healthcare agent by signing a Health Care Proxy form. A lawyer is not required, but two witnesses must be present and must also sign the form. Members who have questions or would like additional information on these issues should be directed to the Member Services department.

A Living Will allows the member to define his/her wishes about the type and amount of care that will be provided or withheld at the end of life. Examples of the types of care that may be addressed in a Living Will include the use of ventilators, intubations, and other life-saving procedures, as well as the areas of nutrition and hydration therapy.

Inpatient facilities must determine if a member has executed an Advance Directive or that the member is aware of the possibility of doing so. If the member has completed a Health Care Proxy, a copy should be kept in the member's inpatient chart or medical record, or the name, address, and phone number of the healthcare agent should be documented in the member's inpatient medical records. It must be clearly documented in the inpatient medical record that the member has executed an Advance Directive.

Copies of both forms can be found in the Member Handbook.

Providers must document in all Healthfirst Medicare member medical records that there was a discussion about Advance Directives and a Health Care Proxy, and the documentation must be updated annually. If the member is hospitalized at the time, the documentation can include that the member was given the information about Advance Directives in the hospital.

If the facility feels that it is unable to adhere to the member's wishes, the hospital should notify the member of this fact and recommend that he/she contact the Member Services department. Otherwise, Healthfirst expects the facility to adhere to the member's wishes as determined by the chosen healthcare agent.

5.5 Disclosure Restrictions for Services Paid Out-of-Pocket

If at the time service is rendered, a Healthfirst member (or their representative) pays for services out of pocket, in full, and they request to restrict the disclosure of their PHI to Healthfirst, participating provider must comply with this request. Participating provider should employ a method to flag or notate the participating provider record with respect to the PHI that has been restricted. This will ensure that the PHI is not

inadvertently sent to or made accessible to Healthfirst for payment or healthcare operations purposes, such as audits conducted by Healthfirst.

5.6 Critical Incident Reporting

Effective Date: November 1, 2012

Pursuant to Special Terms & Conditions, #28, c) ii), the State, through its contracts with MCOs, shall ensure that a system is in place to identify, address, and seek to prevent instances of abuse, neglect, and exploitation of its enrollees on a continuous basis. This includes critical incident monitoring and reporting to the State and investigations of incidents.

General Definition—A "Critical Incident" is any actual or alleged event or situation that creates a significant risk of substantial or serious harm to the physical or mental health, safety or, well-being of a Nursing Home, LTSS, Home Health, Adult Home, and Home- and Community-Based Service participant.

Reportable Critical Incidents Defined

- Abuse
- Neglect
- Mistreatment
- Injuries of unknown origin
- Sexual abuse
- Verbal abuse
- Misappropriation of resident property has occurred
- Medication error/drug diversion
- Burns
- Attempted suicide or death related to suicide, restraints, equipment
- CPR concerns
- Accidents related to choking or equipment hazard; resident found in nonresident area
- Elopement from building
- Physical environment

Critical Incident Management and Reporting: Provider Responsibilities

As a participating Healthfirst provider, you will be required to report all allegations of abuse, neglect, and exploitation of a member, as defined in the Critical Incident Manual. Take immediate action to assure the member is protected from further harm and respond to emergency needs of the member.

Who is supposed to report a critical incident? Facility/staff member who becomes aware of a critical incident as defined on this form. Qualified Service Providers that are enrolled with the Department of Human Services, Transition Coordinators, and Case Managers are required to report incidents.

Incident Reporting Procedure

How do you report a critical incident? Complete the Critical Incident Report form on the HCS Internet Portal https://commerce.health.state.ny.us within 24 hours of knowledge of the incident, any day of the week or time of day.

Using your username and password, log on to the HCS Internet Portal and proceed to the Nursing Home Surveillance and Reporting System to enter information on the electronic Incident Form. Instructions for the Incident Form can be found either by clicking on the Instruction link found on the left-hand side of the form, or through the Instruction link found within the Dear Administrator Letter section.

The Incident Reporting Line phone number, 1-888-201-4563, may be used in case of an emergency such as loss of Internet or computer service. If circumstances dictate reporting via the hotline, that contact will be sufficient and there will be no need to report online. If a provider continues to report via the hotline, they will be redirected to the website.

PLEASE NOTE:

For purposes of facility reported incidents, long-term care facilities must report abuse, neglect, and misappropriation within 24 hours after the reasonable cause threshold is concluded. All other reportable incidents are to be communicated to the NYSDOH by the next business day.

Detailed information and general Q&A on critical incident reporting can be found in the New York State Department of Health Nursing Home Incident Reporting Manual